

PEDIATRICS FOR PARENTS™

The Newsletter for People Who Care for Children

A Letter from the Editor

I have been publishing *Pediatrics for Parents* for over 25 years. I started the newsletter because my patients wanted more information than I could provide during an office visit. From that beginning the newsletter has grown to a 16-page monthly publication sent to over 200,000 readers. It has grown from containing only articles I wrote to featuring articles from doctors and pediatric experts from all over the world. And now there's a podcast that's downloaded nearly 2,000 times each month.

There are two reasons for this letter. First, I want to learn more about you, the subscribers. I designed a short survey that should take you only a few minutes to complete. The survey will help me continue to offer the best publication I can by knowing more about the readership, what features of the newsletter benefit you most, and how the newsletter can improve. Click [HERE](#) to complete the survey. Your participation is invaluable.

Second, as the newsletter has expanded, so have the expenses. We have charged for the printed version of the newsletter primarily to cover printing and mailing costs and have been able to offer the PDF version for free. But just because the PDF version is free to you doesn't mean that it is free for me to produce. *Pediatrics for Parents* has not made any profit in the past 25 years. In fact, I have lost money at times.

Over the next few months you will see a couple of changes. The most significant one is the creation of a free monthly email newsletter. It will contain a brief description of all the articles in that month's issue with links to each article on the *Pediatrics for Parents* website.

The second change is that I will continue to produce the 16-page PDF version of the newsletter, but it will now cost \$5 per year. So for less than the price of two lattes at your local coffee shop, you will be able to continue to receive 16 ad-free PDF issues a year of *Pediatrics for Parents*. I think it's well worth the small cost and hope you do, too.

Some things will stay the same. I will still publish the print version of the newsletter. Our medical writers and columnists will continue to write informative and educational articles on myriad pediatric issues. We will still offer free podcasts on our website. And we will continue to strive to be the best no-frills parenting publication out there. Thank you for your continued support.

- Rich Sagall, MD

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Pediatrics & Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Gender Selection

Want to have a baby boy? Then the mother-to-be should eat a high-energy diet around the time of conception. According to research by Dr. Fiona Mathews of the University of Exeter, UK, 56% of women who ate a high-energy diet around the time of conception had a boy, compared to 45% of the women who ate a low-energy diet. In addition, the women who had boys ate not only a high-energy diet, but also ate a wider range of and more nutrients such as potassium, calcium, and vitamins C, E, and B12. There was also an association between eating breakfast cereals and having a boy.

Worldwide, the average energy intake in developed countries has declined. Dr. Mathews said, "This research may help to explain why in developed countries, where many young women choose to have low-calorie diets, the proportion of boys born is falling."

Proceedings of The Royal Society B: Biological Sciences, 4/08

One Less Treatment for Bedwetting

Last December, the Food and Drug Administration (FDA) warned health-care professionals about using desmopressin to treat primary nocturnal enuresis (PNE, or bedwetting). The drug, a popular bedwetting treatment, poses a significant risk for severe hyponatremia (low blood sodium level), which can cause seizures and even death.

A review of 61 post-marketing studies found that desmopressin, sold as DDAVP, Minirin, and Stimat, caused a number of cases of hyponatremia-related seizures. The nasal spray form of desmopressin has been banned, and although the tablet form still has many other uses and can be prescribed for primary nocturnal enuresis, it should be stopped when a child is ill with a disease that may lead to fluid and/or electrolyte imbalances, such as fever, recurrent vomiting or prolonged diarrhea. Vigorous exercise, certain psychiatric problems, and certain medications may also cause a significant fluid increase resulting in an electrolyte imbalance.

Desmopressin is a replacement hormone for antidiuretic hormone (ADH) and helps decrease urine production. When the kidneys filter out less water from the blood, certain electrolyte levels decrease due to dilution. This can lead to various problems, including hyponatremic seizures.

If your child is on desmopressin to control bedwetting, then you should contact your child's physician.

FDA Alert, 12/4/2007

Childhood Obesity: Who's to Blame?

By Vikki Sloviter

That thirty percent of this country's residents are overweight should not surprise anyone, and research on this growing trend – epidemic as some call it – indicates that we are not getting any healthier. Rates of type 1 and type 2 diabetes are at record highs, and healthcare professionals point to our fast-food and sedentary lifestyles as the primary culprits. Many critics have pointed to our nation's schools and charged them – through government organizations such as the U.S. Department of Agriculture and the Department of Human Services – with improving children's diets by overhauling school lunches. They argue that since children spend so much time in school it only makes sense that schools provide nutritious meals and plenty of physical activity for our youngsters. So it may be surprising to learn that parents may be as much to blame for childhood overweight and obesity as schools.

In a study that appeared in the April 2007 issue of *The American Journal of Public Health*, researchers at Ohio State University found that non-school environments such as homes contribute to an overweight problem in children as much as, if not more than, school environments. Culling 1998-2000 data from the Early Childhood Longitudinal Study-Kindergarten Cohort (ECLS-K), Paul T. von Hippel, PhD and his colleagues found that kindergarten and first-graders' body mass indexes (BMIs – a reliable indicator of body fat that is determined by taking someone's height measurement and dividing it by the square of his weight) fluctuated or increased during summer months, when the children were not at school but at home. The results of this study contradict – or at least weaken – the current belief that schools, not parents, are to blame for our childhood obesity problem.

The study looked at a subset of 5,380 children from 310 schools (out of 17,212 children from 992 schools involved in the ECLS-K study) whose BMIs were measured at the beginning of kindergarten, end of kindergarten, beginning of first grade and end of first grade. The researchers wanted to determine if and at what point the children experienced atypical or non-average BMI gains. Traditionally, children's BMIs follow a J-shaped curve where their BMIs fall from birth to about age five or six, then slowly and steadily increase to adulthood. So the ages at which the children's BMIs for the study were measured (ages five and six) were also the age at which they would have had the lowest BMI measurements.

The data showed that the children started kindergarten with an average BMI of 16.205 units (28.44 pounds) then gained an average of .02 BMI units per month during kindergarten (or a total of five ounces during kindergarten), and an average of .033 BMI units during first grade (or just over eight ounces during first grade). In the three-month summer between kindergarten and first grade, however, those students gained an average of 0.07 BMI units per month, more than twice the growth rate during the preceding or succeeding school year; they gained as much weight in three months of summer vacation (5.8 ounces) as they did during the previous nine months in school. The study also found that the children who were overweight (had above-average BMIs) at the beginning of kindergarten also experienced above-average BMI gains and were at increased risk for adult obesity. And, interestingly, whereas the average-weight children slowly and steadily gained BMI during their kindergarten year as expected, the overweight children lost BMI during that time.

The researchers also wanted to determine if the atypical BMI gains were related to sociodemographics, so they looked at variables such as race and ethnicity, poverty, age, gender and maternal education and work status. Only the racial/ethnic variable showed a relationship with the seasonal BMI growth. Accounting for all other variables, black and Hispanic children were 0.32 and 0.47 BMI units, respectively, heavier than white children on the first day of kindergarten. And, during the summer between kindergarten and first grade, black and Hispanic children gained an average of approximately 0.07 BMI units more than white children.

Von Hippel and his team acknowledged the limitations of their study and discussed possible alternative explanations for the results they found. Among them, one could argue that the accelerated BMI gains in the summer are due to maturation, or some kind of "growth spurt." But, the researchers explained, the noted BMI gains were in fact seasonal, because the increased BMI gain seen during the summer decreased in first grade, not accelerated as would be expected in maturation.

So what are we to take away from this study? Those who previously believed that schools, with soda machines and fattening lunches, were to blame for childhood obesity may need to consider that parental influences are just as important as schools in affecting children's

health. While schools certainly need to revamp their menus and provide at least adequate physical education, they do provide a structured environment that helps limit excessive weight gain. The fact that there is limited time to eat during the school day (in fact, parents often complain their children don't have enough time to finish their lunch) may help children maintain healthy BMIs. Contrast meals during the school year with those during summer vacation, when children have more opportunities to eat during the day and for longer periods of time, and one can begin to understand why children may gain more weight during the summer.

One cannot and should not expect schools alone, or parents alone, to raise healthy children. Schools certainly need to provide healthy food and plentiful exer-

cise, but parents, too, need to provide the same. The results of this study indicate that children's eating and physical behaviors need to be consistent year round to maintain a healthy growth rate. The good news is that some solutions already exist: many children participate in summer programs that keep them healthy and active, and some children even attend year-round schools. The bad news is that clearly some children do not have summer opportunities to keep them healthy. Our next solution is to come up with a way for all children to be able to maintain healthy lifestyles year round so they can become healthy and productive adults.

Vikki Sloviter received her BA in History of Science and Medicine from Yale University. She lives in Bucks County, Pennsylvania with her husband and three young children.

Childhood Asthma

By Rita K. Cydulka, MD, MS

Asthma is a chronic inflammatory disorder of the airways that affects almost 10% of children, making it the most common chronic disease of childhood. Last year, children with asthma missed an estimated 12.8 million school days due to their disease. If not well controlled, asthma may limit a child's activity and sense of well being, and place a significant burden on the family. Although the death rate from asthma has declined, following a rise from the 1980s until the mid-1990s, poorly controlled asthma still accounts for more hospitalizations in children than any other disease.

Asthma may be diagnosed at any age, although doctors are frequently reluctant to label very young children with a chronic disease like asthma, as there are many causes of wheezing in infants and toddlers. As children reach school age, symptoms and triggers become more identifiable and predictable, thereby making an asthma diagnosis easier.

Asthma symptoms include shortness of breath, cough, wheezing, and chest pain or tightness, and they may vary from person to person. A variety of situations, such as allergen exposure (e.g., pollen, dust mites, animal dander, house dust, cockroach droppings or mold, etc.), infections (colds, upper respiratory illnesses, etc), exercise, changes in the weather, and exposure to airway irritants (e.g., cold air, chemicals, tobacco smoke) can trigger symptoms. Severity of asthma is variable, as well. While some children have occasional mild symptoms, others may have daily severe symptoms.

Three-quarters of a million children come to the emer-

gency department every year for treatment of asthma. Rest assured that if your child needs emergency care, emergency physicians are well trained to treat your child's asthma emergencies. Although emergency physicians want your child to lead a fully active, energetic life without ever having to visit the emergency department, we will be there to get him back in action as quickly as possible. Now that spring is here, this is an ideal time to put together an asthma management plan so that you and your child can practice it and make adjustments with your doctor before the real trouble starts with the fall allergy and winter flu seasons. A good plan, organized with your child's doctor and written before an emergency, may help your child stay out of the hospital altogether.

If you are not sure if your child has asthma, but he has asthma symptoms (coughing, wheezing, shortness of breath), talk to your doctor. After a child has been diagnosed with asthma, you and your child should meet with your doctor to develop a plan for monitoring asthma symptoms (usually a peak flow meter), recognizing problems, adjusting medications and adding special medications, such as corticosteroid pills or liquid, when trouble develops.

Since asthma is a chronic disease, many children will need lifelong medications. There are two main types of medications for asthma: controller medications and rescue medications. Controller medications decrease airway inflammation in an ongoing basis and rescue medications quickly and briefly open up the airways. Types of controller medications that you may have

heard of are inhaled corticosteroids and leukotriene modifiers. Rescue medications tend to be inhaled, short-acting, beta-agonist drugs, most commonly prescribed as albuterol and levalbuterol in the U.S.

Children with occasional asthma attacks will only need to use rescue medications when they get an attack. On the other hand, children whose ability to participate in their normal daily activities or desired activities are disrupted by their symptoms, those who require frequent use of rescue inhalers, and those with frequent nighttime symptoms will likely benefit from two types of medication: controller medications/inhalers that they use daily to prevent asthma attacks and rescue medications/inhalers that they use to relieve symptoms. Consistent use of controller medications can prevent many asthma attacks and help children lead normal, physically active lives. How and when medications are used may vary from season to season, depending on what an individual child's triggers are. The medication plan developed with your child's doctor should fit in with both your and your child's lifestyle. Control of this disease requires active participation and partnership among you, your child and your child's doctor.

Although pre-teens and teens are more independent than younger children in many areas, they need close parental monitoring for signs that their asthma symptoms are worsening, as children this age may test their independence and be less compliant with medications than desired. That children aged 11-17 have the lowest rate of emergency department visits but the highest rate of death from asthma highlights this important point.

Whether or not your child needs daily medication or occasional medication, all children with asthma should carry a rescue inhaler with them or have one readily available to them at school. It is important that when children develop symptoms, they and their caregivers or teachers know how to administer the medication and do so quickly. In addition, do what you can to limit your child's exposure to his or her asthma triggers.

For example, if your child is allergic to furry animals, minimize his or her exposure to them at friends' houses and in the classroom at school. If cold air is a trigger, arrange for your child to exercise indoors during the winter instead of outdoors. If dust is a trigger, replace carpeting with wood, tile or vinyl floor coverings. Also, be sure to get your child a flu shot as soon as it is available in the fall. A recent study by the Centers for Disease Control and Prevention showed that only 30 percent of children with asthma get the flu shot, even though flu can be fatal for people with asthma.

Even with the best planning, some children will have asthma attacks that require immediate attention from an emergency physician at the emergency department. The following conditions should prompt a call for emergency help (911 in most areas):

- Symptoms do not improve quickly after the use of rescue inhalers
- The child strains to breathe or cannot complete a sentence without pausing for breath
- The child's lips or fingernails turn blue

Treatment of this kind of asthma emergency is best handled by an emergency physician at a hospital, rather than by parents at home, as medications, oxygen, and any equipment needed are readily available.

In summary, asthma is the most common chronic disease of childhood. With proper planning and care, children with asthma can attend school daily, participate in any activity they choose, and avoid visiting the emergency department altogether.

Rita K. Cydulka, MD, MS, is associate professor and vice chair of emergency medicine at MetroHealth Medical Center and Case Western Reserve University in Cleveland, OH. She is a member of the steering committee of the NIH's National Asthma Education and Prevention Program.

ADHD and Sudden Deaths

Congenital heart defects are much more common in children with attention deficit-hyperactivity disorder (ADHD) than in other children. Some studies have found 40% of children undergoing surgery for congenital heart defects are also diagnosed with ADHD. Stimulant drugs used to treat ADHD, such as Ritalin and Concerta, affect the heart the same way exercise does. This may increase the chances a child with undiagnosed heart disease will have heart problems or even a heart attack.

Because of this increased risk, the American Heart Association (AHA) recommends that any child being started on a stimulant drug for ADHD should have a baseline electrocardiogram (ECG). In addition, the assessment should include a detailed patient and family history, and a physical examination.

According to Victoria L. Vetter, MD, chair of the AHA committee issuing the report, each year sudden cardiac deaths account for five to ten percent of all childhood deaths. However, in up to half of these sudden deaths the children had no previous warning symptoms.

Circulation, 4/08

Unequal Milk Output Between Breasts: Is This Normal?

By Pamela D. Hill, PhD, RN, CBE, FAAN

Mothers of a preterm infant who is hospitalized in the neonatal intensive care unit (NICU) due to immaturity and perhaps other medical problems are separated from their baby after birth. These mothers must use an electric breast pump to initiate and maintain their milk supply because their baby is not able to suckle at breast. Often these mothers experience more milk coming out of one breast than the other when they express their milk via a breast pump. Some wonder, "Is this normal?"

This important question asked by pump-dependent mothers of a non-nursing preterm infant was the impetus to re-examine our data from our last study. We asked if there was a difference in milk output between breasts as measured as volume when pumping both breasts simultaneously over a period of six weeks after delivery.

The Study

In our study, mothers were all English speaking, 18 years or older, had access to a telephone, delivered a preterm infant < 32 weeks gestation that weighed ≤ 1500 grams (3.3 pounds), and planned to lactate a minimum of 12 weeks. None of the mothers smoked nor had an endocrine disorder such as diabetes mellitus or thyroid disease.

Mothers were provided a special electric breast pump and instructed to record daily in their logbook at each pumping session the number of minutes they pumped and the amount of milk expressed separately from the right and left breast into a special collection bottle. The recording of this information occurred the first 42 days after delivery.

Because mothers were recruited and entered the study at varying times during the first few days following birth, study day six after birth was chosen as the first day to report as milk output data were available for all 95 subjects. For the 37 study days (days six through 42 after birth) there were a total of 3488 days, and a total of 570 weeks for the 95 mothers who completed the study.

Right vs. Left Breast Milk Output

Out of the 3488 total study days, the left breast was dominant 1800 (51.6%) days; the right breast was dominant 1598 (45.8%) days. For 90 of the 3488 (2.6%) study days there was no breast dominance. When the

right breast was dominant, the mean daily output from that breast was 308.8 ml/d, compared to the left breast output of 249.9 ml/d. When the left breast was dominant, the mean daily output from that breast was 293.7 ml/d, compared to the right breast output of 241.5 ml/d. Expressed milk output was different between breasts regardless if the right or left breast was dominant.

Similarly, for the 570 study weeks, the left breast had a greater milk output 53.3% (n = 304 weeks) of the time; the right breast had a greater output 46.7% (n = 266 weeks). In total, over the course of the 37 study days, milk expressed from the left breast accounted for 52.6% of the total milk volume, while 47.4% of the total milk volume was expressed from the right breast.

Conclusions

For mothers who are pump-dependent and delivered a preterm infant, milk output differences between breasts are a common occurrence. From our data, breast dominance — or the breast that had a greater output — was consistent over time. For the most part, mothers had either a dominant right or left breast throughout the entire six-week study period. This information can be used to alleviate any concerns that mothers may have when they see the amount of milk that is expressed into a bottle providing there are no breast pathologies.

Pamela D. Hill, PhD, RN, CBE, FAAN, is professor in Maternal Child Nursing, College of Nursing, at the University of Illinois at Chicago. For the past 22 years Dr. Hill has focused her program of research on mothers who choose to provide mother's milk to their infant. Her latest work involves pump-dependent mothers who deliver a very preterm infant. Her work suggests that this population is at high risk for producing an inadequate milk supply.

Breastfed Babies

Percentage of U.S. babies born in 2004 who have ever been breastfed:

Washington	88.4%	Vermont	85.2%
Oregon	88.3%	Arkansas	59.2%
Montana	87.7%	Mississippi	50.2%
Colorado	85.9%	Kentucky	59.1%
Idaho	85.9%	Alabama	52.1%



Children in Hospitals

By John E. Monaco, MD

When Baby Stops Breathing

Nothing can be more frightening to parents than the sight of their child struggling to breathe. You would be surprised to learn how often we see babies where this is the chief presenting complaint. Rachel is a six-week-old infant we recently admitted to our service whose story is very typical of those we see with this problem.

Rachel was a full-term newborn who had been completely healthy, with the exception of occasionally spitting up after her feeds. Rachel's mother had discussed this issue with the pediatrician, who had cautioned her to burp the baby well and to be careful not to overfeed. He didn't feel any further work-up was necessary at the time.

Rachel's 18-month-old sister had been struggling with a cold, and although the parents had tried their hardest to keep the already inseparable sisters apart, Rachel had, in the preceding day or so, exhibited a few sniffles. These mild symptoms did not concern her parents as they hoped Rachel's cold would not become worse.

Then it happened. Rachel's mother had just finished feeding her, burped her successfully, and then put her down. She turned to do something else, and when she turned back she noticed Rachel struggling. ("Choking" was how mother described it to us.) She noticed a little formula mixed with mucus running out of the corner of Rachel's mouth, and as she picked her up she noticed that she was actually not breathing and her color had begun to turn from her normal pink to pale to a little bluish. She reflexively wiped the mucousy vomit away and began to stimulate Rachel to breathe. Within seconds (although it seemed much longer) Rachel took a big deep breath and cried lustily. She remained irritable but continued to breathe effectively. The mom called 911 and Rachel was brought to our hospital for evaluation and treatment.

Upon arrival, the nurses evaluated Rachel and hooked her up to the monitors, which continually recorded heart rate, respiratory rate and oxygen saturation. Any obvious cardiac or respiratory problems would declare themselves early in this process. Rachel was completely

normal from a cardiorespiratory standpoint, other than the slight respiratory infection. A chest X-ray was done and her nasal mucus was swabbed to check for RSV (respiratory syncytial virus), which in babies can occasionally present with apnea (cessation of breathing). The X-ray and the RSV test were both negative. We informed Rachel's mom that many respiratory viruses can produce thick mucus secretions which, if thick and voluminous enough, can cause obstruction of the airway. Even though the RSV test was negative, other viruses could, especially in an infant under two months of age, cause the choking and color change that Rachel had demonstrated.

The following morning, we ordered an upper GI exam, which gave us further insight into Rachel's problems. In this exam the radiologist gives the baby formula laced with the chemical element barium, which shows up on X-rays. The radiologist uses a fluoroscope to follow the column of barium down the esophagus into the stomach. In Rachel's case, this otherwise smooth flow was interrupted by fairly significant reflux of the barium back up into the esophagus. This is what is typically seen in gastroesophageal reflux, or GER. Other ways to diagnose this problem in infants would be to conduct a sleep study with a probe into the stomach to monitor acid reflux.

From what we had done so far, we surmised that Rachel suffered from GER, the effects of which were exacerbated by her respiratory infection. The thick mucus from the infection had combined with the formula, which had refluxed back up into her esophagus and mouth, to almost completely obstruct her airway. Her choking and turning blue were the manifestations of this airway obstruction.

Knowing what had caused Rachel's breathing problems was only half the battle. Sending Rachel and her mother home with the confidence that it wouldn't happen again was the other half. This took a two-pronged approach. First, we treated the respiratory infection with breathing treatments, chest physiotherapy and

Continued on page 9



"Baby Doc" Eden Explains

By Alvin N. Eden, MD

The Terrible Twos: Denaturing Discipline

Negative behavior, including temper tantrums, breath holding and head banging are all part of normal development and so should be expected when your child is about two years old, but may start even earlier. It can be very difficult to manage, but it should not come as a surprise. Some call this period of your child's life an early form — or preview — of the adolescent rebellion period. Whatever it's called, it is a real challenge for the parents of these difficult-to-handle toddlers.

Children must be taught to control their behavior on a day-to-day basis so that they eventually learn to rely on themselves and not on adults to know the difference between right and wrong. However, there is much disagreement as to how best to accomplish this. What is the best way to manage unacceptable behavior, that is, to discipline a child?

What do we mean when we think about disciplining a child? The word "discipline" comes from the word "disciple," someone who follows the teaching of another. Discipline, therefore, refers to the learning experiences you give your child and does not mean punishment. A teacher-pupil relationship is what proper discipline should be all about. Unfortunately, many parents as well as professionals equate discipline with punishment. Obviously there are times when punishment may be needed to discipline your child, but discipline is not synonymous with punishment.

Try to put yourself in your toddler's shoes: from his point of view, there are valid reasons to misbehave. For example, breath holding is a very effective way to get your attention. Other times, he may be learning a new skill such as smashing dishes on the floor. Often a temper tantrum is the only method he knows to express frustration. I do not for a moment advocate that you should approve such behavior, but at least try to understand why it happens. There will be times when you will have to act promptly and effectively to prevent an accident. In such a situation, forceful action is necessary.

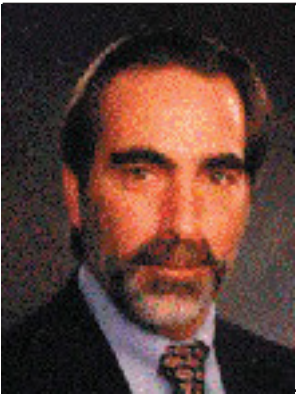
Let me give you two examples of poor and ineffective discipline techniques:

1. **Screaming and yelling:** There are times when your toddler will drive you crazy with his unacceptable behavior. At such times it becomes difficult or almost impossible to control yourself, so you shout out your frustrations. You may feel better by screaming, but it gets you nowhere in solving the problem. All yelling does is increase the conflict and often provokes even more destructive behavior. It is important to always remember that children learn by example.
2. **Your child is bad:** If every time your child does what you consider something wrong and you call him "bad" it won't be long before he will start believing you, and that will surely not build up his self-worth or self-image. Many parents have a hard time understanding that when their youngster misbehaves or breaks the rules, he is not being bad and doing it to cause trouble. He has just not yet learned to behave properly. Your job is to teach him to do so, but not by calling him derogatory names.

Frustrated and angry parents sometimes react to negative behavior by physically striking or verbally abusing their misbehaving child. Not only is this reaction the wrong way to motivate your child, but also it doesn't work and often makes things worse. Instilling fear in your child is the wrong way to teach her right from wrong. Shaming, humiliating or beating a child all are psychologically damaging and are, in my opinion, examples of child abuse. It sets the absolutely wrong example. Further, it is well known that abused children often grow up to be child abusers as adults.

In my article next month I will discuss a number of effective techniques that will help teach your child right from wrong. Your goal is to help him stop destructive tendencies and temper tantrums and to encourage self-control and self-discipline. It takes time and patience, but it can be done. There is light at the end of the tunnel.

Dr. Eden is the chairman of the department of pediatrics, Wyckoff Heights Medical Center, Brooklyn, New York and a clinical professor of pediatrics, Weill Cornell Medical Center, New York, NY. His latest book, Positive Parenting, is now available.



Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Infants and Child Care

How young is too young to be placed in a child care center?

Many facilities accept infants as young as six weeks of age. And many parents, eager to resume working, are dropping off their tiny progeny early in the morning and then picking them up in the late afternoon. Clearly, this is convenient and even lucrative for the adults involved. But what about the babies? Are they basically going to be okay, or does this place their psychological health in serious jeopardy?

Well, I certainly don't want to be an alarmist, so right off the bat I will say that most infants who are spending the bulk of their day in a child care center are probably doing reasonably well. However, I also have to say that I am extremely concerned that we gradually are ceasing to think about some significant issues. And if we start to take things for granted and neglect to keep those issues in mind, it will be very easy for this situation to turn into a major disaster.

We are well aware that a baby who is abused and neglected during the first months of life is likely to develop enormous psychological problems, and that even if his treatment improves substantially later on, it may be extraordinarily difficult if not impossible to undo the damage that has been done. What many people seem to be unaware of these days is that in order to ensure psychological health, the care that the baby receives must be prompt, responsive, and loving. If the care is adequate but impersonal, he will be physically fine, but there is a good chance he may suffer psychologically.

How do we know this? We do an experiment. We take a bunch of babies and divide them into two groups. One group is given prompt, responsive, and loving care. The other is fed, bathed, and diapered, but everything is done in an assembly line fashion that does not permit them to develop meaningful relationships with their caregivers. We then see what happens. The first group turns out great. The second does not.

Obviously, it would be unethical to do such research. Regrettably, it was done, informally and unintentionally. During the last weeks of World War II, several European

cities were the targets of extremely intense bombing, and hundreds of thousands of people were killed in a short period of time. As a result, thousands of little babies were left orphaned. When the bombing stopped, rescue workers went in and found those babies and did their very best to take care of them.

Unfortunately, there were so many babies and so few rescue workers that the best that could be done was to set up orphanages with row after row of cribs. The workers were good people who worked hard. But all they could do was race up and down the rows, changing diapers and propping bottles. So if you were a comfortable baby with a full belly and a clean diaper, it didn't matter. If it was your turn, off went the diaper and in went a bottle. Meanwhile, if you were a screaming baby who was starving and had soiled your diaper, it didn't matter either. You had to wait your turn.

In other words, all the babies received adequate physical care. But it was provided in a mechanical manner that did not permit them to establish a real emotional connection with their caregivers. Consequently, as time went by, many of those babies began to experience rather severe psychological difficulties that plagued them for the rest of their lives.

Now I don't want parents to panic. As important as the process of establishing good connections may be, it is quite forgiving. If you don't meet your baby's needs immediately every time, and even if you fail to meet your baby's needs on occasion, he won't grow up to be an axe murderer. You have to go a long way to cross the line. However, one should never forget that the consequences of crossing that line can be devastating.

So let's take a look at the child care situation. The National Association for the Education of Young Children recommends that the infants-to-caregiver ratio be no more than four-to-one, and most states make that the regulated ratio. Why is the number four? Well, you would like to believe it is based on the needs of the babies. But the fact is that it is essentially a financially based figure. You go below four-to-one, and child care becomes quite expensive.

I routinely speak to conventions of early childhood professionals, and I like to bring up this subject. When I ask why the ratio is four-to-one, the response is almost always a simple, “That’s what the recommendations and regulations are.” They really haven’t given it much thought. I then note that there are a couple of jurisdictions where the regulations make the ratio three-to-one. The professionals all nod their heads and say, “That’s ideal. I wish we had three-to-one. That’s ideal.”

Later on, during a break, I casually mention that our daughter-in-law recently gave birth to triplets. Suddenly, these professionals are screaming, “Triplets! How will she manage? She’s going to have help, isn’t she?” It seems like out in the real world, the notion of one person trying to take care of three babies at a time is unimaginable. You’ve got to have help. But in the world of child care, it’s “ideal.”

This is crazy. My wife owned and directed the largest private child care center and preschool in our state for many years. The infants in her care did receive the kind of prompt, personal, loving attention they required, but it was extraordinarily hard work. Every available staff person was sent into the baby room to help out and keep the infants-to-caregiver as low as possible – and that routinely was lower than the state-regulated ratio. And the parents were constantly urged to ensure that their little ones spent no more time in the facility than was absolutely necessary.

On the other hand, I have seen facilities where there seems to be a lack of concern. Sometimes the staff plays fast and loose with the regulated ratio if someone calls in sick or if they are generally short-handed. Even if the regulated ratios are respected, in many facilities there is such a high staff turnover rate that it is virtually impossible for the infants to form and maintain consistent relationships. And all too often I’ve seen mothers and fathers dropping off their babies early in the morning and not picking them up until late afternoon five days a week.

Again, I would hesitate to say that large numbers of infants are greatly at risk. But I would suggest that parents think carefully about placing their babies in child care. Since children do not develop a genuine and substantial interest in peer interactions until they are two years of age, socialization is not an issue. And there is nothing in the educational realm that child care personnel are more qualified than parents to provide for at least the first three years.

Therefore, the only significant benefits that come from placing babies in child care are increasing family income and keeping careers on track. I don’t mean to

imply that those things are trivial. But giving one’s child a solid foundation for lifelong psychological health is a sacred responsibility that should be given higher priority. And given the dire consequences of failing to do so, it definitely is not wise to skate too close to the edge.

I would never presume to tell anyone precisely what decision should be made; and, in fact, I routinely recommend part-time child care if for no other reason that to give the parents a much-needed and well-deserved break. But I strongly urge everyone to avoid slipping into a pattern where things are taken for granted and critical issues are not considered sufficiently or even ignored. Just think about it. Would you want to spend the entire day, five days a week, trying to care for four babies? And more importantly, would you want to be one of those four babies?

Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., “The Education for Parenthood Information Center,” a family advisory and advocacy agency located in Lindenhurst, IL. He may be contacted via e-mail at epicntrinc@aol.com.

Stop Breathing – Continued from page 6

suctioning, and kept Rachel in the hospital three or four days until we were confident the secretions could be handled with the bulb suction device that every parent of a newborn possesses. Then, to deal with the GER, we instructed Rachel’s mom on positioning (head of bed elevated, with right side slightly downward after feeding) and showed her how to thicken feedings (one teaspoon of cereal per ounce of formula) to prevent overfeeding. We also placed Rachel on a small dose of Zantac to ameliorate the symptoms of gastric acid spilling up into the stomach. (Other medications may be used if the reflux is more severe.)

After Rachel’s mother was instructed in infant CPR — a skill all parents of newborns should learn — she left the hospital with Rachel, fairly confident that she not only understood why her daughter had experienced a frightening breathing difficulty, but more importantly that she knew some strategies to deal with it in the future.

John E. Monaco, MD, is board certified in both pediatrics and pediatric critical care. His new book, Moondance to Eternity, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Check out the Pediatrics for Parents podcast at www.pedsforparents.com



Children's Emergencies

By Martin Belson, MD

Dog Bites

Most dogs do not bite, but any dog has the potential to bite at any time. Because dog bites are a common injury for children in the U.S., it is important for parents to learn what they can teach their children to lessen the risk of being bitten.

Incidence

Every year, over 4 ½ million people in the U.S. are bitten by a dog, and most of the victims are children. Twice as many children require medical care after their bites than do adults. In the past decade, dog bites have increased by 33%. Dog bites are among the most frequent cause of injury in children. They are more likely to lead to a hospital visit than an injury incurred on the playground. In a 2006 study of 341 children who were bitten by a dog, 85% suffered deep wounds and 27% required hospitalization. The majority of dog bites in children occur in the summer months.

Children Most at Risk

In a 2006 study published in the journal *Pediatrics*, children less than one year of age were most likely to be bitten by a dog. Boys are more likely to be bitten than girls. Children less than nine years of age are most likely to be bitten in the head or neck area.

Dogs Most Likely to Bite

The majority of dogs that bite belong to the victim's family or to a friend. Most dog bites occur at home or a familiar place. Pit bull-type dogs and Rottweilers, followed by mixed breeds and German Shepherds, have been shown to cause the most number of dog bite-related deaths in the U.S. In a 2006 European study, German Shepherds and Dobermans were at the top of the list of dogs most likely to bite.

Characteristics of dogs most likely to bite include:

- Male gender
- Non-neutered
- Chained up
- Poorly trained
- Little social interaction
- Has puppies
- Sick or injured
- Overly excited

- Disturbed while sleeping

Rules to Follow

The general rule for parents is not to leave a baby or small child alone with a dog. Parents should teach their children the following ten rules to lessen the risk of being bitten by a dog:

- DO NOT pet a dog without asking the owner's permission.
- DO NOT go near an unfamiliar dog.
- DO NOT sneak up on a dog.
- DO NOT tease, hit, or pull on a dog.
- DO NOT disturb a dog that is sleeping, eating, or caring for puppies.
- DO NOT go near a growling dog or one that is showing its teeth.
- DO NOT run up to or scream around a dog.
- DO NOT run past a dog that may get it excited and aggressive.
- DO NOT move if a dog sniffs or approaches you – stay calm even if not threatened.
- DO NOT try to get up and run if knocked down – curl up in a ball and put your hands over your face and head.

Treatment

In the majority of cases, unless just a small scrape is present, your pediatrician or an ER doctor should evaluate a dog bite in your child. If possible, the wound should be cleaned with soap and water right after the injury, but this may be difficult with young children. If bleeding is present, apply pressure to the wound with an appropriate size first aid bandage or dressing to control the bleeding.

Medical Care

In general, the following steps may be taken in the treatment of your child's dog bite:

1. Wound cleaning: How much will depend on the size of the wound, where on the body it is, and how dirty the wound is.
2. Stopping any bleeding
3. Wound repair: Some wounds may be required to

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Pediatric Points

By Carolyn Roy-Bornstein, MD

Cold Treatments: the Good, the Bad and the No Longer Available

Children average six to seven upper respiratory infections (URIs or colds) a year. For kids in day care, that number can be closer to eight or ten. Considering that each cold lasts seven to ten days, that's potentially a lot of sleepless nights for these sick kids and their exhausted parents. And if your kids are in the under-two crowd, you may find yourself with fewer medications in your bag of tricks given the recent removal of these drugs from the marketplace. But in my opinion, that's not necessarily a bad thing. In fact, I'm glad the Food and Drug Administration (FDA) and the American Academy of Pediatrics (AAP) have begun recommending what I've been telling parents for years: kids don't need drugs for colds! Let me give you a little background as to how and why this withdrawal came about.

In January of last year, The Centers for Disease Control and Prevention (CDC) reported the deaths of three infants that were determined by medical examiners to be caused by the administration of over-the-counter (OTC) cough and cold preparations. Two months later the FDA was asked, through a citizens' petition, to review the use and labeling of these OTC products in kids under age six. In August of 2007 the AAP suggested changing the labeling to read, "This product has been shown to be ineffective in the treatment of cough and colds in children under the age of six years. Serious adverse reactions including but not limited to death have been reported with its use, misuse and abuse."

In October of 2007 the manufacturers of OTC cough and cold medications, represented by the Consumer Healthcare Products Association (CHPA), voluntarily withdrew from public shelves all cough and cold meds labeled for "infants." That same month an FDA advisory panel and the Pediatric Advisory Committee met and voted to recommend not using these medications in children under six without further studies.

But haven't these products been around for years? Yes, they have. The FDA approved many of these products for general use over 30 years ago. The problem is that there had been little or no evidence that these prod-

ucts were safe or effective in children. And because no scientific studies existed, there were no scientifically based dosing recommendations.

In 1974, a panel of physicians recommended using half of an adult dose for children aged six to 11 and one quarter of an adult dose for kids aged two to five. Parents were instructed to "consult a physician" for babies under two. The FDA adopted the guidelines. But there were numerous problems with these recommendations. For one thing, the extrapolated dosing instructions were based on average weights. Not only did this method not take into account the wide variation in weights of children in the same age group, but also it failed to recognize the many differences between adult and pediatric physiology.

Children's livers and kidneys, the organs that do a lot of the drug processing, are less mature than an adult's. Also, the percentages of fat and water, in which medications are diluted or stored in the body, differ widely. Some would even argue that colds may not behave the same way in children due to their smaller airways, sinuses and less robust immune systems. Further, the recommendation that parents consult their pediatricians for dosing of children under two implies that doctors have access to some studies or formulas for calculating those doses when in fact such formulas don't even exist. Then there is the matter of efficacy. There has been no evidence from scientifically conducted studies that OTC medicines work in kids.

So what does work? Alternative and herbal therapies such as Echinacea and zinc have been studied as treatments for or prevention of colds for many years. The results have been mixed at best.

Echinacea has been postulated to modulate the immune system and enhance the ability of white blood cells to ingest germs. Unfortunately, a recent study comparing Echinacea with placebo in children aged two

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Pediatric Insider

By Roy Benaroch, MD

Pacifiers

Q How do I get my one-year-old son to stop using his? Will using it cause

him any harm?

A I'll admit I'm kind of a softie on the pacifier issue. They help little kids relax, and are much less harmful than many of the things adults do when they're feeling anxious. Think about it – at least your son isn't smoking or drinking! At one year of age, a pacifier certainly isn't doing any sort of permanent harm to your child's teeth or mouth. If he seems to find using a pacifier a good way to relax, I'm not sure you need to worry about it or get him to stop using it.

A good rule of thumb would be to try to limit pacifier use to his crib or bedroom starting at age two. That's a good time to teach him to throw it back in his bed when he gets up. You can also gently suggest he go to his room for time with his "lovey" when he does get anxious, upset, or frustrated at that age. By age four, it's a good idea to stop pacifier use entirely – though by then, almost all kids will have stopped on their own.

If your son's pacifier use is really bothering you, you can stop it at any time. Just throw them all away, all at once, and don't look back. After only a few days it will be as if he never used one. It might be a rough couple of days, but if you decide that the pacifier has got to go, it's best to do it all at once. You may have heard about a method of cutting the pacifier shorter every few days, but that may lead to choking on fragments. I no longer recommend this method.

Eat Your Vegetables

Q How can I make my 5-year-old son eat his vegetables?

A Some rules cannot be broken. The three unbreakable rules of raising children are: You can't make them sleep, you can't make them eat, and you can't make them poop. Making a child eat veggies isn't

something that parents ought to do.

Though you can't make a child eat vegetables, there are things you can do to encourage him to eat a larger variety of foods as he grows older. But keep in mind that some kids — and even some adults — are going to be picky eaters. There are many adults here in the United States who never, ever eat a vegetable of any kind, without suffering any ill effects. Many foods are fortified, so your child is likely getting all the vitamins he needs even without the veggies.

Encouraging a child to eat a variety of foods starts with breastfeeding. Nursing, rather than feeding formula, offers very young babies a chance to experience a variety of tastes, and breastfed babies are more likely to accept a variety of flavors later.

When babies are ready to start solid meals, it's very important to eat as a family. Children at every age should eat with their parents, so parents can model good eating behaviors: accepting a variety of foods, using

table manners, and enjoying good conversation during a meal. (The benefits of family dining extend well beyond the picky toddler years. In teenagers, studies have shown that family dining helps prevent obesity, academic problems, and substance abuse.)

Once toddlers are past baby foods, they should be offered the same foods as everyone else in the family. Don't assemble separate plates of food for each member of the family. Instead, have everyone sit down in front of an empty plate and help him or herself to serving platters of food ("family style" dining). Parents should not get up to prepare something different if everything on the table is refused. Getting up to make different foods for the kids encourages them to develop a habit of always refusing the first foods offered. It's perfectly fine if some of the items on the table are things that the kids usually eat, but those ought to be part of the meal from the beginning, not added on at the end at a child's request. And they ought to be on serving plates from which everyone can help themselves to a portion, not on individual "kid's plates."

Don't make some foods available only if other foods are eaten. For example, you might be tempted to make a

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

rule, “you can only get a brownie if you eat your broccoli.” That’s a bad idea. It makes the brownie seem extra-super special, and makes the broccoli seem extra-super bad. It reinforces the idea that broccoli is terrible, and that no one would eat it unless they got a super-special food – brownies! – afterwards.

A better plan is to decide in advance what things are in the meal, and if brownies are part of dinner, just include them on the table at the beginning. Anyone can have his brownie whenever he wishes. Don’t make some foods more “special” than others. (An even better plan for those brownies is to avoid “dessert” altogether, saving sweet treats for special times outside of regular meals. A regular meal’s dessert should be fresh fruit, maybe with some whipped cream on top. Yum!)

One goal of mealtimes is to reinforce this message for each individual of the family: Eat when you’re hungry, and don’t eat when you’re not hungry. Mealtimes should also be a time for families to communicate and share experiences together, and to learn important manners and social skills. Avoid using coercion, tricks, or rewards to get your child to eat what you think he ought to eat, or to eat as much as you think he ought to eat. You’ll have happier, healthier mealtimes, and you’ll help your child develop healthy food attitudes for his entire lifetime.

Dr. Roy Benaroch is a general pediatrician in practice near Atlanta, Georgia, and an assistant clinical professor of pediatrics at Emory University. He’s a frequent contributor to Pediatrics for Parents and has written two books for parents.

Dog Bites – Continued from page 10

heal without repair, such as a small puncture in the skin from a dog’s tooth – closure of a puncture wound can increase the risk of infection. Some bites may require the skills of a plastic surgeon or orthopedist.

4. Antibiotics will be started for some wounds caused by dog bites.
5. Tetanus vaccination or a booster may be required.
6. Rabies vaccination may be required – your physician, health department, or local poison control center (1-800-222-1222) can give you guidance.

Martin Belson, MD is a pediatric emergency medicine physician at Children’s Healthcare of Atlanta at Scottish Rite, a medical toxicologist, creator / editor of www.kidemergencies.com and host of the Pediatric Health Hour every Wednesday at 9AM on www.radiosandysprings.com. He is also the author of www.kidemergencies.com, a free resource on children’s health emergencies.

Cold Treatments – Continued from page 11

to eleven years who had colds failed to demonstrate a positive effect. In over 700 children with over 400 colds, no shortening of cold duration or decreased severity of cold symptoms was seen. Not only that, but children using the Echinacea experienced rashes significantly more frequently than those using placebo.

Results for zinc were only slightly more promising. A recent review of the literature by a professor at Stanford University School of Medicine found that in the four studies of zinc that were the most rigorous, three showed no effect on severity or duration of cold symptoms. One study reported a positive effect using zinc nasal gel, but it was a study on adults that did not include any children. Also, serious side effects of intranasal zinc have been reported, notably a permanent loss of the sense of smell!

Other potential problems with herbal remedies include contamination, poor packaging information and unknown toxicities due to the lack of research on safety and efficacy. Herbal therapies are not FDA approved or reviewed and there are no official standards for purity and labeling.

One home remedy for cough relief that has received a lot of attention recently is honey. A study in December of 2007 showed that honey was more effective than dextromethorphan, a common ingredient in many over-the-counter cough medicines, in treating cough from cold. The World Health Organization has long argued that honey is soothing to many patients and can help decrease cough associated with sore throat.

We still don’t know exactly how honey works. It may increase production of saliva and swallowing or it may coat the nerve receptors that trigger cough. It’s also possible that it influences the production of endogenous opioids, those “feel good” substances responsible for the so-called “runner’s high.” In any case honey is cheap and apparently effective. It is also safe for most people. One important group for whom honey is not safe is babies under a year of age. Honey should not be used in this age group due to the risk of paralysis from botulism.

The point is, about the only known cure for the common cold is the tincture of time. With or without treatment, whether traditional or alternative, pharmaceutical or herbal, a good seven to ten days generally does the trick.

Carolyn Roy-Bornstein is a board certified pediatrician in private practice in Haverhill, MA.

Recognizing Sexual Abuse in the Young Child

By Patricia A. Corbett, RN

According to the American Medical Association, “Child sexual abuse is the engagement of a child in sexual activities for which the child is developmentally unprepared and can not give informed consent. Child sexual abuse is characterized by deception, force or coercion.” It can further be described as any sexual contact between an adult and a minor or between two minors when one exerts power over the other. It encompasses a broad range of activities including voyeurism, fondling, exhibitionism, exposure to pornography, and oral, anal, and genital contact. Exposing a child to sexual stimulation inappropriate to the child’s role in the family is another example of sexual abuse.

According to statistics from the Darkness to Light National Advisory committee on sexual abuse, 93% of all victims know their abusers. Sixty-seven percent of reported assaults occur to children under age seventeen; twenty-two percent are under age eight. One in four girls and one in six boys are sexually abused before their eighteenth birthday. Preschool children and infants are not exempt.

It is the responsibility of parents and caregivers to help protect their children against sexual abuse. The perpetrator is usually known to the child and is often a “trusted” adult, a family member, or family friend. Authority figures such as teachers, coaches and parents know that young children are taught to do as they are told. Boundaries can become blurred and make it difficult for children to recognize certain kinds of attention as abuse.

Victims are often coerced into secrecy with threats of family harm. Because the abuser is often someone the child knows and trusts, the child becomes confused and frightened. The child may blame himself and feel guilty, therefore never reporting the abuse. This profound breach of trust can cause long-term emotional, physical, and psychological damage. Later consequences can include poor self esteem, a deep sense of shame, difficulties with intimacy, feelings of worthlessness, inability to trust, withdrawal and depression, unexplained anger, rebellion and problems with communication and interpersonal relationships.

What are the Signs of Sexual Abuse?

Some children will show no obvious signs that they have experienced sexual abuse. Physical symptoms or complaints of sexual abuse are not common but may

include belly pain, lack of appetite, bruises, itching or scratches in the genital area, redness or inflammation in the genital area, pain with urination or defecation, rectal pain or bleeding in the genital area. Behavioral changes may include loss of bladder and bowel control, precocious flirtation, simulation of sexual acts with dolls, regression such as newly manifested clinging, change in sleeping patterns or inability to sleep alone, unusual fears and phobias, bedwetting, sadness and crying, nightmares, excessive masturbation, and eating problems. Personality changes can be seen with acting out behavior, easy distractibility, irritability, renewed need for security objects, and sexualized behavior inappropriate to the child’s developmental level.

What Can I Do?

Help your child to know his body. Talk about what different body parts do. Use proper terminology and language that your child can understand. Keep in mind the intellectual developmental level of your child. Be open to questions about genitals and be matter of fact. Teach about privacy. Be clear with him about questionable touching. Teach him never to keep a secret about his body. Talk to him about what kind of touches feel OK, and what kind do not feel OK. Tell him that if something or someone makes him feel “funny” or uncomfortable, or if he feels afraid or unsafe, he needs to tell you about it. Give examples such as, “No one should touch the parts of your body covered by underwear.” Teach him not to touch someone else’s body even if that person asks him.

If either situation occurs, tell your child to yell loudly and shout, “NO!” Tell him to run away, or kick or bite. Tell him to find someone to tell and if the first person does not listen, keep telling until someone does.

Since more than 80% of sexual abuse happens in a one-adult/one-child situation, minimize those opportunities. Think carefully about your child’s safety and look for group activities. If your child is alone with an adult, drop in unexpectedly. Avoid risks and base your decisions regarding your child on reality.

What if My Child Tells Me?

Believe him. Listen carefully and be as calm as possible. It is difficult for a vulnerable child to tell a parent something so troubling. If you react with anger or disbelief,

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Caring for Children in Hospice

By Sandra Gardner, RN

The death of a child may be the most devastating experience a parent can face. Unfortunately, death knows no age limit and parents all too often lose their children to accidents and illness. Parents cannot prepare for a child's sudden and unexpected death. But when children are terminally ill or have a debilitating chronic illness and require a comfortable environment, parents need to have some control over their care. According to Children's Hospice International, of the approximately 100,000 children who die each year in this country, a quarter die from a chronic illness. Only 10% of these children use hospice services.

Children's hospice enables the child to remain in the home, to continue to attend school and interact with friends while under the care of a hospice team and a twenty-four hour caregiver, often the parent. Having children in hospice care also enables the parents to make informed decisions about their child's end-of-life care. The main focus of hospice is quality of life, as the team helps to relieve the pain and other uncomfortable symptoms induced by the child's illness during this time.

The hospice team consists of the child, the child's family, their physician, nurse, social worker, physical therapist and chaplain.

The physician and nurse coordinate the child's medical care. They conduct a thorough physical exam, a medical and social history and formulate an overall plan of care with the family. They assess the family's understanding of the child's illness and options for treatment and teach them according to their needs. They continuously monitor for progress and adjust the plan as needed. According to Mary Kay Tyler, MSN, CNP, pediatric nurse practitioner and director of the Pediatric Palliative Program at Hospice of the Western Reserve, the diseases that children have often do not follow the same predictable disease course as those of adults, so children often receive curative and palliative therapy concurrently. Children are likely to die from the "in-between" events, such as infections.

The social worker helps to alleviate financial concerns and works with social services at the hospital for any

needed inpatient care. The social worker assesses the mental and emotional status of the family and refers them to community and nationwide organizations that can help. Social services also helps the family adjust to their new situation and obtain assistance they need.

The physical therapist performs a thorough assessment of the child's physical needs and teaches the family and child how to help themselves. The therapist helps the child learn new ways to walk, to transfer, to turn and also teaches movement and also teaches the family members how to help the child when he cannot help himself.

The chaplain is trained to guide the family through the grieving process and to cope with death and dying. He ministers to the spiritual and psychological needs and works with the family's own minister if they have one.

Each child's care is individualized and age appropriate, and addresses the medical, psychological, social and spiritual needs of the family as one unit. Respite care is also available for the caregiver if the task of taking care of her loved one gets to be too difficult.

Hospice care extends beyond the illness and death of the child to grief and bereavement services for the family. These may include in-home visits, telephone calls and support groups. Caldecott Award Winner

Chris Raschka's book *The Purple Balloon* (Schwartz and Wade Books, 2007) helps parents find the right words to talk to their children about the dying process.

Finally, most insurance carriers, such as Medicare, Medicaid and private insurance, pay for hospice care. Families without insurance may receive hospice through charitable funds donated to a hospice organization or through private funds. Some major hospitals may also provide financial assistance. For more information, contact your state's hospice organization or your local hospitals.

Sandra Gardner, RN, has eleven years' experience in public health nursing. She lives and works in Missouri.

Additional Resources

Children's Hospice International
(www.chionline.org)

Children's Hospice and
Palliative Care Coalition
(www.childrenscarecoalition.org)

Caring Connections
(www.caringinfo.org)

The Partnership for Parents
(www.partnershipforparents.org)

National Hospice and Palliative Care
Organization (www.nhpco.org)

The National Center of Medical Home
Initiatives for Children with Special
Needs
(www.medicalhomeinfo.org)

Sexual Abuse – Continued
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it may frighten him. Thank him for telling you. Tell him it is normal to feel afraid. Assure him he did nothing wrong and that it is not his fault. Reassure him that you love him and you are there for him to keep him safe. Make sure he knows he will not be punished. Support him continuously and be non-judgmental. Try not to ask questions, but if you must, ask open-ended questions such as, "What happened next?" Be patient and take as much time with him as he needs.

Seek professional help for you and your child. Expert guidance can be critical to the child's – and parent's – healing. Be aware of your own reactions and take action in reporting the abuse, regardless of whether or not the offender is an immediate family member. The safety of your child is far more important than any family conflicts. The child is depending on you to do the right thing. Criminal prosecution of the offender is paramount to ending the cycle of abuse. Two resources include Child Protective Services and your local police. Or call the Child Help USA National Child Abuse hotline at 1-800-422-4453.

Patricia A. Corbett R.N., M.S.N. is an incest survivor who has practiced as a pediatric nurse for over 35 years. She has worked with many families that have sexual abuse histories. Her dream is to empower caregivers to feel comfortable discussing sexual abuse with children. Patricia is a school nurse on Cape Cod.

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